UTAH MEDICAID REFORM BILL – S.B. 180
DISCUSSION OF 1115 WAIVER - MEDICAID REFORM PRINCIPLES
PROVIDER FOCUS MEETING – PROVIDER ASSESSMENT AND UPL PRESERVATION
MAY 4, 2011 – CANNON HEATLH BUILDING ROOM 125
3:30-5:00 P.M.

Attendees: Michael Hales, Representative Dean Sanpei, Rod Betit, Sheila Walsh-McDonald, Shanie Scott, Richard Rosenberg, Paul Muench, Brian Okasu, Gail Rapp, Randy Baker, F. Blake Anderson, Kris Fawson, Lincoln Nehring, Jim Murray, Jesse Liddell, Aaron Eliason, Ed Dieringer, Nate Checketts, Curt Peterson, M.D., Jason Cooke, Todd Wood, Lisa Fallert, Sean Dunroe, Dave Gessel, Kathy Konishi, Julie Day, Collin Davis, Gordon Crabtree, Barb Viskochil, Vicky Wilson, Russ Elbel, Marshall McKinnon, Michelle McOmber, John Curless, Gayle Coombs

Michael called the meeting to order at 1:35 p.m. He explained that the topic for today's meeting is Provider Assessment and UPL Preservation. Michael said that by way of background, in the 2010 Legislative session, the State created a hospital assessment based on inpatient hospital days and that is basically the vehicle by which the State has tried to maintain the Federal funds that were available previously in the reimbursement structure prior to reimbursement rate cuts. Michael said that ends up being over $100,000,000 a year in State and Federal dollars included in the reimbursement for inpatient hospital services in the State. This is a substantial part of the reimbursement that Medicaid puts into the hospitalization services.

Michael said the current assessment is based on fee-for-service inpatient hospital days. On the teaching hospital side of the equation, we have graduate medical education payments that go to the University of Utah Hospital and some smaller hospitals. This is one of the considerations we have before us as to how we design these payments.

Michael mentioned direct medical education and disproportionate share hospital payments. Michael said we are trying to figure out how to structure reimbursement so we will use all available DSH dollars.

Michael said he thinks we can work through all of these issues in the new environment. There may have to be some changes on how these payments are passed on to the providers. Michael said we will start with hospitals first and take on the other parts later.

A question was asked in regard to the physician side of things. Are we going to have the ability to adjust these payments? Michael said we could discuss these things.

Michael said in general in terms of the physician's payments, we will maintain a fee schedule. However, along the Wasatch Front, the physicians will have to see what their arrangement is with the health plans and see what their new contract arrangement will be. The physicians need to be affiliated with one of the Accountable Care Organizations (ACOs). Michael said the contracts are between the health plans and the physicians.

It was asked if any waivers will be needed in regard to this, and Michael said he did not think so. Michael mentioned what he felt would be the key issues in working through the contracts. Rod Betit had a comment in regard to this. He asked if some new waivers would be needed with the ACOs so they would not be in violation with Federal law. Michael said he would have some of our legal staff look at this issue.

There were some comments made in regard to how the different providers are working with some of the health plans on some of these things. They are also working on similar relationships with their hospital groups.

Michael then mentioned we are working with CMS on the hospital assessment and how the payments will be made and preserved in the future. Michael mentioned how we can use assessment derived general funds or tax revenues in a capitated managed care or accountable care type of contract. CMS said as long as we use the amount of money that has been historically put into the system our actuaries could construct the rate using those allowable costs.

The money will be allowed to be included in the rate for the ACOs but the getting it to the hospitals has to come through the contracts with the ACOs. The State will not be able to direct how these payments go out. Michael said right now the supplemental payments have a very complicated algorithm on which the payments are distributed. Michael gave some examples of this.

Michael said there are a number of individuals that are not on Medicaid but are eligible for Medicaid. If they end up in the hospital, and then apply for Medicaid, they will be given Medicaid for 90 days. Michael said these days are part of the assessment and he said we need to look at how this will be looked at going into the future. Michael mentioned different ways the State could look at this. He mentioned how we would need to be looking at modifying the assessment. He said we are willing to explore any plan that is put forward. He said they will have e to meet the quality standards and be able to distribute payments? Michael mentioned how some of these things would fall under the authority of the Insurance Department.

Michael said we will need to work through how we reconfigure the hospital assessment going into the next legislative session. Michael said there are definitely some key issues that we will need to work through.

Michael said up to this point, the University of Utah Hospital has not been considered in this assessment. A lot of comments were made in regard to this.

Representative Sanpei was asked what the legislative intent is in regard to this. Representative Sanpei mentioned that there are different buckets where all this money comes from. He mentioned that the challenge with this is how do we keep the dollars flowing in an appropriate way. He said we want to maintain fairness and equity. Representative Sanpei said there are definitely some challenges that will have to be figured out in regard to what is equitable.

Michael said the good news is that in aggregate, the money can be left in the system.

Michael said the next discussion item is the IGTs and how we can handle that. He mentioned Graduate Medical Education (GME).

John Curless then talked through the different options we have in working with these disability payments. He discussed the lump sum payment options. John said that CMS has told us that we cannot direct how these payments will go. John made some comments in regard to disproportionate hospital payments. John said that DSH overall is to pay for uncompensated care costs for services to Medicaid recipients and the uninsured. He also mentioned the upper payment limit and what CMS would allow us to do.

Representative Sanpei had some comments in regard to the flexibility for this plan. Michael mentioned some different things that the State could do with this. Michael said that in assessment driven payments, CMS said we cannot put in the contract how much goes to specific hospitals. Michael was asked to get more information from CMS on this. It was mentioned that if the State could get a waiver on this, that could really help.

Representative Sanpei said they are trying to give the entities who will take on these populations more flexibility. GME and DSH and keeping them separate was mentioned. Fee-for-service days and managed care days were mentioned. A lot of comments were made by Barbara Viskochil in regard to this. She thinks it would be a good idea to look at the GME distribution separately. Michael said these are the key issues that we are laying out on how we go from where we are to the new way it will be. He said we need to decide how we are going to work through restricting this and end up in a stable type of environment. Michael said that even though the Federal Government has its new rule on what an ACO means, in the CMS world that we are dealing with for our waiver, our capitated plans will probably still be considered a Managed Care Organization and not subject to the Medicare ACO regulations. Michael said there are a lot of different flavors of what an ACO means, but the governing regulations that we think are ACO modeled would take on the ACO regulations that the Federal Government has outlined for Medicaid health plans.

Michaels said next week we will be talking about the quality piece. We will be talking about the NCQA proposed quality standards as well as the current standards imposed on managed care organizations that we have to have the contract with the EQRO.

Michael thanked everyone for being here and adjourned the meeting at 4:50 p.m.

Would there be any value in having different provider groups to deal with Medicare and Medicaid ACO's? Representative Sanpei said their intent is not to limit the providers, but, their intent is to limit the patients to staying in one group.